## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
185327			B. WING			05/40/2000			
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SPENCER COUNTY				STREET ADDRESS, CITY, STATE, ZIP CODE 625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071					
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	was initiated on 05/ 05/12/2020. The fa compliance with 42 regulations and has Medicare & Medicai Centers for Disease (CDC) recommende COVID-19. Total ce	sed Infection Control Survey 11/2020 and concluded on cility was found to be in CFR 483.80 infection control implemented the Centers for id Services (CMS) and c Control and Prevention ed practices to prepare for nsus 88.	FC	000					
BUKATURY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN.	ATURE		TITLE		(X6) DATE		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
185327			B. WING	i	0:	05/12/2020	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SPENCER COUNTY				STREET ADDRESS, CITY, STAT 625 TAYLORSVILLE RD TAYLORSVILLE, KY 4007	E, ZIP CODE	712,2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		ACTION SHOULD BE TO THE APPROPRIATE	OULD BE COMPLETION	
E 000	A COVID-19 Focus Survey was initiated concluded on 05/12	sed Emergency Preparedness d on 05/11/2020 and 2/2020. The facility was found with 42 CFR 483.73 related	EC	000			
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/21/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 100603 B. WING 05/12/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **625 TAYLORSVILLE RD** SIGNATURE HEALTHCARE OF SPENCER COU TAYLORSVILLE, KY 40071 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 05/11/2020 and concluded on 05/12/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE